# Stillbirth management

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| **Target audience** | Maternity staff |
| **Patient group** | Women/birthing people in NHS Lanarkshire affected by stillbirth. The term 'women/birthing people' is used within this document to include women, girls, trans men, and non-binary and intersex people, who are pregnant or have recently been pregnant. |

## Introduction

This situation must be handled with the utmost compassion; families may need time to come to terms with the situation. Acknowledge the family's feelings and permit them to be alone if they so wish. The significance of the family's loss must be acknowledged and appropriate emotional, psychological and spiritual support must be available to assist the grieving process in response to individual need. The family must be treated with dignity and their privacy and cultural beliefs respected. No assumptions should be made about the intensity and duration of grief that a family will experience. It is important that staff accept, acknowledge and validate the feelings that any individual family member is experiencing.

Diagnosis should be confirmed by ultrasound by two experienced members of staff, one of whom should be a consultant. If the mother has attended by herself, staff should immediately offer to contact a person of her choice to provide her with support. Mothers should be prepared for the possibility of passive fetal movements.

As a supplement to the verbal information given by care givers, families should be given written information at this time providing them with options for the care to follow. The link for the SANDS Bereavement Support Book is available in maternity triage.

Urgent delivery is indicated if there is sepsis, abruption/antepartum haemorrhage, severe pre-eclampsia or ruptured membranes. The method of delivery and/or induction of labour in these circumstances should be individually planned based upon the presenting condition, past obstetric and past medical history.

In uncomplicated cases the timing and process should be discussed with the family by a senior obstetrician. The choice of expectant management or induction of labour should be offered. In the majority of cases parents will choose induction of labour, however if expectant management is chosen a management plan should be discussed and documented by the obstetrician. In cases of multiple pregnancy the timing and mode of delivery will depend upon chorionicity, gestation and the presentation of the fetuses. Parents should be advised that if expectant management is chosen the value of post mortem examination is reduced and the appearance of the baby may deteriorate.

## Investigations to be completed at diagnosis:

- Full blood count
- Group and save
- Kleihauer (for all women/birthing people, even if RhD positive) - if Rh negative, give appropriate dose of anti-D (may require further dose after delivery – the fetal blood group should be ascertained on cord blood testing)
- Urea and electrolytes
- Liver function tests
- Lupus anticoagulant
- Anticardiolipin antibodies
- Prothrombin gene mutation
- Factor V Leiden mutation
- Thrombophilia screen
- HbA1c
- Erythrovirus B19
- High vaginal swab
- Placental swab
- Fetal swabs (ear, nose, mouth, anus)
- Full set of observations with documentation on a Modified Obstetric Early Warning Score (MEOWS) chart

## Management

### General principles

Care in labour should be the same as normal care of labour as per NHS Lanarkshire guidelines including the use of partogram and observations. Whilst the completion of relevant paperwork is important, care for the woman/birthing person and her family should be the priority. A consent form should be signed before medication administration.

- If maternal cervix is favourable, consider induction by forewater amniotomy followed by oxytocin.
- If maternal cervix is unfavourable, follow the induction regimen indicated below.

### Mifepristone

Mifepristone is an antiprogestogen which sensitises the cervix and uterus to the effects of prostaglandins. When used in conjunction with misoprostol it has been found to reduce the duration of labour.

Vomiting is a known side effect of mifepristone. It is therefore important to allow time for absorption so women/birthing people should be asked to wait for 20-30 minutes prior to going home.

Mifepristone takes approximately 36 hours to become effective. Due to the small risk that mifepristone alone could cause miscarriage, women/birthing people should be advised if heavy bleeding per vaginum or passing blood clots occur at home she should contact maternity triage and return to hospital immediately.

**Misoprostol**

Misoprostol is given vaginally unless there are exceptional circumstances when the oral route can be used. Women/birthing people should be advised that vaginal misoprostol is as effective as oral therapy but associated with fewer side effects.

**Contraindications to mifepristone/misoprostol:**

• Chronic adrenal failure
• Long term corticosteroid therapy
• Known hypersensitivity to mifepristone, misoprostol, prostaglandins
• Inherited porphyria
• Haemorrhagic disorder (bleeding disorder)
• Concurrent anti-coagulant therapy

**Caution (consultant to be involved):**

• Renal impairment
• More than one caesarean birth – see below under special situations
• Previous uterine surgery – see below under special situations

## Regimens

**24+0 – 33+6 weeks of gestation:**

- **Part 1:**
  - mifepristone 200 milligrams is administered orally
  - Risk assess woman/birthing person for location of delivery (labour suite vs. O'Hana suite)
  - discharge the woman/birthing person home with emergency contact details and a plan to return in 36-48 hours
  - Patients should be advised on the following:
    - Abdominal cramps/mild vaginal bleeding – normal and to be expected
    - Severe pain or bleeding more than a normal period – contact maternity triage
    - Pain relief options - paracetamol, codeine, ibuprofen

- **Part 2:**
  - Admit patient to designated area (labour ward or O'Hana suite) 36-48 hours later (preferably 10am)
  - Arrange for her to be met by a designated midwife
  - Administer misoprostol 200 micrograms per vaginum every three hours (up to a maximum of five doses).

- **If therapy is unsuccessful:**
  - On-call consultant to be notified
  - Consideration to be given to the use of vaginal prostaglandins or an intravenous oxytocin infusion.
  - Caesarean birth may be indicated following discussion between the woman/birthing person and her consultant

**34+0 weeks of gestation onwards:**

Labour should be induced with prostaglandins using the dosage regimen described in the induction of labour guideline.

- **If therapy is unsuccessful:**
  - On-call consultant to be notified.
  - Consideration to be given to the use of further prostaglandin doses.
  - Caesarean birth may be indicated following discussion between the woman/birthing person and the consultant.

**Other factors to consider:**

**Analgesia**

- Opiate analgesia such as morphine (or diamorphine) is useful in most cases.
- Following discussion with the anaesthetist, a PCA (patient-controlled analgesia) consisting of morphine may be considered. An epidural may too be considered but this is gestation-dependent and should be discussed with the anaesthetic team.

**Oxytocics**

- No evidence/history of hypertension - after 20 weeks of gestation, ergometrine with oxytocin (also known as 'syntometrine') 500 micrograms/1mL solution is to be administered intramuscularly at delivery of the fetus.
- Current/previous hypertension – after 20 weeks of gestation, syntocinon 5 international units is to be administered intravenously at delivery of the fetus.

**Anti-D**

- Anti-D should be given to those patients who are rhesus negative as per related guideline.
- The guidelines for fetal loss should be read in conjunction with the above.

## Special situations

1. Women/birthing people with more than one caesarean births from 12+0 weeks of gestation onwards.

2. Women/birthing people with a history of previous uterine surgery , previous classical caesarean birth / inverted ‘T’ shaped incision from 12+0 weeks of gestation onwards.
3. Women/birthing people with a previous caesarean birth with gestation 24+0 weeks of gestation and above
    a. Plan of care should be individualised.
    b. If the situation warrants, a second opinion could be obtained from any of the consultant obstetric team.

# References


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# Clinical governance

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|---|---|
| **Lead author:** | G Buchanan |
| **Current responsible author:** | G Buchanan |
| **Endorsing body:** | ADTC |
| **Version number:** | 3 |
| **Approval date:** | 19.11.25 (ADTC) |
| **Review date:** | 19.11.28 |

| **Consultation/distribution record** | |
|---|---|
| Contributing authors: | V Grove (Bereavment specialist midwife), G Buchanan (Cons O&G) |
| Consultation process: | MCEG/ADTC |
| Distribution: | All in maternity via RDS app |

| **Change record** | | | |
|---|---|---|---|
| **Date** | **Lead author** | **Change** | **Version** |
| Feb 2020 | V Grove | Original | 1 |
| 9.10.24 | G Buchanan | General update | 2 |
| 19.11.25 | G Buchanan | General update, addition of thrombophilia screen, new guideline format | 3 |